DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-05

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.12

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 55,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B
#2.c., Pages 1-10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B
#2.c., Pages 1-11

10. SUBJECT OF AMENDMENT:
Federally Qualified Health Centers

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Janet Schalansky

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary

15. DATE SUBMITTED:
03/28/01

16. RETURN TO:
Janet Schalansky, Secretary
Social & Rehabilitation Services
6th Floor, DSOB
915 SW Harrison
Topeka, KS 66612

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
03/29/01

18. DATE APPROVED:
JUN 27 2001

19. PLAN APPROVED - ONE COPY ATTACHED

20. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/01

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on back

"Substitute per letter dated 6/20/01"

KANSAS MEDICAID STATE PLAN

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#2.c. Federally Qualified Health Centers

Effective January 1, 2001, Federally qualified health centers enrolled in the Kansas Medicaid Program shall be reimbursed for covered services furnished to eligible beneficiaries under a prospective payment system (PPS) in accordance with the requirements of section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. An alternative payment system that assures the amount determined under the Medicaid PPS mandated by BIPA as minimum reimbursement, will also be available to providers at their option. An FQHC shall be reimbursed using the alternative methodology only if the provider agrees to it. Under both options, reimbursement for services covered by Medicare plus dental services shall be made through an all-inclusive encounter rate determined by the agency for each qualified visit.

When a federally qualified health center furnishes "other ambulatory services" excluding dental services, the Kansas Medicaid Program shall reimburse the provider using the methodologies utilized in paying for same services in other settings, provided all requirements under the state plan are met. "Other ambulatory services" are those which do not meet the Medicare definition of federally qualified health center services, but are covered under the Medicaid state plan.

1. ENCOUNTER BILLING

The federally qualified health center program under the Kansas Medicaid Program complies with scope, definitions, criteria, and basis of payment for FQHC services under Medicare set forth in 42 CFR Part 405.2411 and 405.2446 through 405.2452, and Publication 27.

1. Billable Visit or Encounter
A federally qualified health center "visit" means a face-to-face encounter between a center patient and a center health care professional including a physician, physician assistant (PA), advanced registered nurse practitioner (ARNP), dentist, clinical psychologist, clinical social worker, and for Kan-Be-Healthy nursing assessments only, registered nurse. This may also include a visiting nurse provided all the conditions listed in I(D)(4) are fulfilled. Encounters with more than one certified health professional or multiple encounters with the same practitioner on the same day shall constitute a single visit.

2. More Than One Encounter on the Same Day
If the patient suffers illness or injury subsequent to the first visit on the same day, requiring additional diagnosis and treatment which are different from the first visit, the second encounter will qualify as an additional FQHC visit.

3. Health Care Professional Requirement
A visit shall qualify for encounter payment only if the certified professional is:

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1. employed by the federally qualified health center; or
2. under arrangement to receive compensation from the FQHC for providing covered services; or
3. an owner of the FQHC. This criteria only applies to a physician, PA, and ARNP.

4. Place of Service Criteria
   1. **Services at the Center:** Covered services provided at the center facility by practitioners defined in I(A) & I(B), excluding visiting nurse, may be billed as FQHC visits. Services performed in the center are payable only to the center. Practitioners may not bill for these services under any other Medicaid provider number.
   2. Services Away from the Center: Covered services provided at the patient's place of residence or elsewhere (e.g., at the scene of an accident) by an FQHC practitioner excluding visiting nurse may be billed as a visit only if the practitioner is employed or compensated under agreement by the center for furnishing services to center patients in a location other than the center facility. These services are payable only to the center. The practitioner may not bill Medicaid for these services under any other provider number. If, on the other hand, the practitioner is NOT compensated by the FQHC for provision of services in a location away from the center facility, services provided away from the center shall not constitute FQHC services and the practitioner may bill Medicaid under a professional provider number. However, if these services are furnished during a time period for which he/she is compensated by the FQHC, the center is required to carve out all expenditure associated with these services on the cost report.
   3. Services in a Hospital: Services provided by a center practitioner in outpatient, inpatient, or emergency room of a hospital or in swing-bed do not constitute FQHC services under the Kansas Medicaid Program. These services may be billed under the practitioner's professional Medicaid provider number. However, if these services are provided by a center practitioner during a time period for which he/she is compensated by the FQHC, the center must carve out all expenditure associated with these services on the cost report.
   4. Visiting Nurse Services: Part time or intermittent nursing care provided in a patient's place of residence may be billed as an encounter only if each of the following requirements is fulfilled:

      (1) The FQHC is located in an area designated by the Secretary of Health and Human Services as an area with a shortage of home health agencies;
      (2) the services are rendered to a homebound patient who is confined, either temporarily or permanently, to his or her place of residence as a result of a medical or health condition;
      (3) the "place of residence" may be a private home, a home for the aged, or other type of institution as long as it is NOT a hospital, long term facility, or skilled nursing facility (SNF) which is required to provide nursing care, rehabilitation, and other related services to inpatients as a condition for participation in Medicare & Medicaid SNF programs;
      (4) the services are furnished by a registered nurse (RN) or licensed practical nurse (LPN) who is employed by or receives compensation for providing these services from the FQHC;

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(5) the services are furnished under a written plan of treatment established by a supervising physician, ARNP, or PA of the center which is:
- reviewed at least every 60 days by a supervising physician, and
- signed by a supervising physician, ARNP, or PA of the center;

(6) the services consist of:

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- nursing care that must be performed by an RN or LPN to assure the safety of the patient and to achieve the medically desired results; and
- personal care services to the extent covered under home health services. This does not include household & housekeeping services.

5. Content-of-Service
Content-of-service is a service or supply which does not constitute a billable encounter by itself, but its cost is included in the encounter rate. These should neither be billed as an FQHC encounter nor as a service under any other Medicaid provider number. Examples of services that are content-of-service:
   1. Services furnished by the auxiliary health care staff employed by the center that are "incident to" the services provided by the certified health care professionals.
   2. Administration of vaccine, immunization, or other injection. It does not constitute a billable encounter unless it is of a kind which cannot be self-administered.
   3. Lab procedures performed by the auxiliary health care staff employed by the center.
   4. Professional component of Radiology or EKG if performed by a center health care professional.

6. Drugs & Biologicals That Cannot Be Self-Administered
The only drugs and biologicals covered as federally qualified health center core services are those which cannot be self-administered. Administration of these by a center personnel may be billed as an encounter.

7. Exclusions
Services & supplies, both direct and indirect, not related to patient care and not reasonable & necessary for the efficient delivery of health care services for diagnosis & treatment of center patients are not covered. These should neither be billed as FQHC visits nor reported on the cost report as allowable FQHC expenditure. In addition, the following are not covered as FQHC benefit:
   1. All services furnished by the auxiliary health care staff who are not employed by the center.
   2. Services provided by the FQHC's auxiliary health care employees without direct supervision of a center practitioner.
   3. Technical components of Radiology and EKG.
   4. Health care services performed by outside entities, including those entities which are owned by the center's owner(s) or staff. These include but are not limited to Lab, Radiology, EKG, Pharmacy, PT, and psychotherapy. The State Plan requires that providers of these services bill Medicaid directly.

2. REIMBURSEMENT METHODS

Effective January 1, 2001, the Kansas Medicaid Program will implement the prospective payment system (PPS) for federally qualified health centers to conform with BIPA 2000. There will be no retroactive cost settlements under this system. As an alternative to the PPS, providers will be offered the opportunity for reimbursement under a modified cost-based system (CBS) on facility fiscal year basis. This methodology

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combines features of a cost-based system with the PPS payment level mandated by BIPA. Under this system, FQHCs will be paid the greater of cost-based or PPS-based reimbursement through retroactive settlements. To receive reimbursement under the alternative system for the duration of a specific facility fiscal year, providers will be required to submit written requests on a timely basis according to the schedule outlined in II.B below.

1. Definitions
   1. **Rate** - Payment for each qualified encounter or visit.
   2. Base Years or FY 1 & FY 2 - Current Providers - Facility fiscal years 1999 and 2000.
   3. Base Years or FY 1 & FY 2 - New Providers - Two facility FY's subsequent to the first year of business as FQHC.
   4. Cost-Based Rate or Payment - Based on reasonable cost of covered services.
   5. Baseline Rate - Average of cost-based rates from the base years.
   6. MEI - Percentage increase in the Medicare Economic Index for primary care services.
   7. PPS Rate or Payment - Meets PPS requirements outlined in the BIPA 2000.
   8. Non-PPS Rate or Payment - Does not meet BIPA requirements.
   9. Preliminary - Derived from unaudited cost report(s) or from only one base year.
   10. Final or Finalized - Derived from audited cost report(s) or from both base years.

B. Criteria for Election of the Alternative Payment Option
   1. For facility Fiscal Years Beginning Prior to October 1, 2001 – The request must be received in our office no later than July 27, 2001 or as decided by the state at a later time.
   2. For Facility Fiscal Years Beginning On or After October 1, 2001 – The request should be received in our office no later than forty five (45) days prior to the beginning of the facility fiscal year.
   3. No Request Received - If no request for the alternative payment option is received timely for a facility fiscal year, the provider will be reimbursed under the PPS for that entire fiscal year with no settlement.

3. Cost Reports
   Each provider shall be required to submit a federally qualified health center cost report on facility fiscal year basis using the most recent version of Form HCFA-222-92 (Rev. July 1994) within five (5) months after the fiscal year end. Non-reimbursable costs shall be reported in the appropriate sections of the cost report and shall not be commingled with allowable costs. The cost report should be supplemented by a detailed trial balance which includes cost report line numbers for cross-checking, independent auditor's report & management letter, an itemized list of revenue including source & purpose, and any additional information necessary to facilitate reconciliation of reported expenditures with the trial balance and financial statements. Support for all information must be available for review.
4. Determination of Cost-Based Rate
   1.. Total Reasonable Cost: Total allowable cost of FQHC core services and dental services, after

overhead allocation and revenue offsets, as described in section V.

2. Adjusted Total Visits: Actual visits shall be adjusted by applying a minimum productivity standard of 4,200 hours for Physicians and 2,100 hours for PA, ARNP, and Dentist.
3. Cost-based Encounter Rate: Total reasonable cost divided by adjusted total visits.

3. PROSPECTIVE PAYMENT SYSTEM (PPS)

Under this methodology, rural health clinics shall be paid prospective rates based on an average of the reasonable costs of providing covered FQHC services during the base years, with no retroactive settlement.

4. Determination of PPS Baseline Rate
   1. Methodology - It will depend on the time frames covered by and availability of cost reports as follows:
      (1) Both Base Years Full Twelve-Month Periods: (FY 1 Cost-Based Rate + FY 2 Cost-Based Rate) / 2.

      (2) One or Both Base Years Less Than Twelve-Month Periods:
      [(FY 1 Cost-Based Rate x No. of Mo.)+(FY 2 Cost-Based Rate x No. of Mo.)] / Total No. of Months

      (3) Only One Base Year Cost Report Available: Cost-based rate derived from the available cost report.

      (4) No Base Year Cost Report Available: The lower of current rate (effective on 12/31/ 2000) or average of baseline rates of other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce. The rates will be adjusted for dental services (not provided by all FQHCs).
   2. Frequency - Twice, unless *audited* cost reports from *both* base years are available at the time of initial rate setting:
      (1) Initial Baseline Rate: After the approval of the state plan amendment (for current providers) or at the time of enrollment (for new providers). Initial rate can be preliminary or finalized.
      (2) Final Baseline Rate: When audited cost reports for both base years become available.

B. Payment Procedure for January 1, 2001 to September 30, 2001
   2. Prior to approval of this state plan, Medicaid has continued to pay interim rates effective 12/31/ 2000.
   3. Upon SPA approval, initial PPS baseline rates will be computed using cost reports for facility fiscal years 1999 and 2000 received in our office before July 1, 2001.
   4. Interim payments will be reconciled to the initial baseline rates retroactive to January 1, 2001. In cases where the initial baseline rates are "preliminary", interim payments will again be retroactively reconciled to the "final" baseline rates when available.

3. Payment Procedure for October 1, 2001 to September 30, 2002
   1. PPS baseline rates effective on September 30, 2001 times the MEI index will be set as payment rates.

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2. In cases where the baseline rates used for this rate setting are "preliminary", when "final" baseline rates are available they will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.

4. Payment Rate Effective Each October 1 After September 30, 2002
   1. The PPS rates effective on the previous day (9/30 of the same year) shall be adjusted by the MEI index.
   2. In cases where the baseline rates used for this rate setting are "preliminary", when "final" baseline rates are available they will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.

5. Baseline Rate for New Providers
   1. If Historic Cost Reports Available: If the facility is an established FQHC, historic data from cost reports of the two most recent fiscal years will be used to determine the initial PPS baseline rate. If it is available only from one fiscal year, that will be used for rate setting provided it is at least a twelve-month period. Data covering the first year of business as an FQHC will be excluded.
   2. If No Historic Data Exists, But FQHC Submits Budget on FQHC Cost Report Form: If the facility is not an already established FQHC, the rate may be derived from a budget submitted by the enrollee.
   3. If Neither Historic Nor Budgeted Data Available: If neither is available, the payment rate shall be the average of the rates paid to other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce, with an adjustment for dental services since they are not provided by all FQHCs.

6. Change in Scope of Services
   To receive a PPS rate adjusted for a proposed increase or decrease in the scope of covered FQHC & dental services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditure, and change in total number of visits. Any rate change would be implemented on the first of the month following the SRS decision.

4. ALTERNATIVE METHODOLOGY - "MODIFIED COST-BASED SYSTEM" (CBS)

As an alternative to the PPS, providers may choose to receive the greater of PPS-based or cost-based reimbursement. It will consist of interim payments reconciled to the higher of cost-based or PPS-based amount through fiscal year end retroactive cost settlements.

1. Payment Rates Effective January 1, 2001 to September 30, 2001
   Prior to HCFA approval of this state plan amendment, Medicaid has continued to pay rates that were effective on December 31, 2000. These will be changed to PPS baseline rates when they are computed (see III.B.2).

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2. Payment Rates Effective October 1, 2001 to September 30, 2002
   Baseline rates effective on September 30, 2001 times the MEI index.

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3. Payment Rates Effective Each October 1 After September 30, 2002
   The PPS rates effective on the previous day (September 30) adjusted for the MEI index.

4. Retroactive Cost Settlement
   1. Cost-Based Medicaid Cost: It is total reasonable cost of covered services furnished to eligible Program beneficiaries during the facility fiscal year. It will be determined by applying the cost-based rate determined from the cost report to total covered Medicaid visits obtained from the fiscal agent records.
   2. PPS-Based Medicaid Cost: It is the amount that the provider would have received for covered services furnished to eligible Program beneficiaries during the facility fiscal year under the PPS option. It will be determined by applying the PPS rate(s) to total covered Medicaid visits.
   3. Total Payment Received by Provider: It consists of Medicaid payment, third party liability, and HealthConnect payments obtained from fiscal agent records; and any other related transaction.
   4. Overpayment or (Underpayment): The greater of cost-based or PPS-based Medicaid cost minus total payment received by the provider will be the settlement paid to or (due from) the provider.

5. DETERMINATION OF REASONABLE COST

Reasonable cost consists of necessary and proper cost incurred in providing covered federally qualified health center services and dental services to all patients. Cost reimbursement principles, productivity screens, other limits, and coverage criteria set forth in K.A.R. 30-5-118, K.A.R. 30-5-118a, K.A.R. 30-5-118b, 42 CFR Part 405.2411 and 405.2446 through 405.2452, Medicaid state plan, Medicaid provider manual, 42 CFR Part 413, and Medicare Publications10 & 27 shall be applied to the data submitted to Medicaid as tests of reasonableness.

1. Review & Analysis of Reported Data
   Expenditures & income reported to Medicaid will be reconciled with the trial balance, financial statements prepared by the independent auditor, and the finalized (audited) Medicare cost report. Expenses reported as allowable, including overhead cost, will be analyzed to evaluate if they are accurate, reasonable, necessary, patient related, associated with covered services, and reported in the appropriate cost center. Revenue will be analyzed for refunds received. Any findings will be deducted from reported expenses to yield total allowable cost. The encounter data will be analyzed for reasonableness, accuracy, inclusion of nursing assessments, and visits not meeting the definition of billable encounter.

2. Revenue Offsets
   Income will also be analyzed to confirm that Medicaid payments do not duplicate revenue received from other sources to cover specific programs or expenses, whether in part or whole. If such duplication is found, it will be offset before rate calculation. NOTE: Public Health Service Grants under section 329, 330, and 340 shall not be offset against expenses in determining allowable cost. To prevent such offset, the provider shall clearly identify these grants by name, not just numbers, in the supplemental data

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submitted with the cost report.

3. Total Reasonable FQHC & Dental Cost for the Facility
   Allowable overhead (indirect) expense will be allocated to total allowable FQHC & Dental (direct) costs and total non-reimbursable (direct) expenses based on the proportion of each "direct" cost center to their summation. Post-allocation total FQHC & Dental expenses minus any revenue offsets shall be the total reasonable cost of covered FQHC and Dental services furnished to all patients, regardless of payer.

6. SERVICES FURNISHED UNDER CONTRACT WITH MANAGED CARE ENTITY (MCE)

If a FQHC elects the alternative reimbursement option for a given fiscal year, it will be eligible for a settlement on covered services provided during that time period to eligible Medicaid beneficiaries under a contract with a Medicaid managed care entity (MCE). The settlement will consist of the difference between the amount paid to the FQHC by the MCE and the amount that would have been paid by Medicaid under the alternative methodology, Modified Cost-Based System (CBS), for the elected fiscal year.

1. Quarterly Supplemental Payments
   The FQHC must send copies of the remittance advices received from the MCE to Medicaid after the end of each calendar quarter. Without these, the agency will not be able to make the supplemental payments. The remittances will be reviewed and the procedure-based payment data will be converted to "FQHC encounters", making corrections if necessary (e.g., a payment not meeting the encounter definitions). The state will compute "quarterly alternative amount" by applying the provider's Medicaid interim rate under the alternative system for the corresponding time period to total encounters. If it is less than the MCE payment, the agency will send the difference to the FQHC no more than 90 days from the receipt of the remittance advices.

2. Fiscal Year End Settlement
   When a fiscal year end final cost settlement is determined for Medicaid payments as described in section IV (Modified CBS), the state will also make a final settlement on services provided under the MCE contract during the same fiscal year. An "yearly alternative amount" will be computed using total encounters for that time period obtained from the supplemental payment data and the alternative system methodology. This amount will be compared with total payments received by the provider, i.e., MCE payments plus quarterly supplemental payments. If the computed alternative amount is higher than total payments, Medicaid shall pay the difference to the provider. If, on the other hand, the yearly alternative amount is lower than total payments, the FQHC shall refund the overpayment to the agency.